GOVERNMENT OF GUAM
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES

Division of Environmental Health, Health Certificate Program
Division of Public Health, Communicable Disease Control Program

HEALTH CERTIFICATE CLEARANCE APPLICATION

PLEASE COMPLETE BOX BELOW BEFORE PRESENTING THIS FORM TO YOUR HEALTHCARE PROVIDER

Applicant's Name: _____ **Citizenship:** _____
Last **First** **Middle**

Birth Date: _____/_____/_____ **Social Security #** _____- _____ - _____ **Sex:** ☐ **Male** ☐ **Female**
(Mo.) (Day) (Year)

Contact Number: (Work) _____ **(Home)** _____ **(Cell)** _____

Mailing Address: _____

Residential Address: _____

Place of Employment: _____ **Location:** _____

Job Title: _____ **Ethnicity/Nationality:** _____

I certify that the information provided above is true and accurate to the best of my knowledge:

SIGNATURE: _____ **Date:** _____

NOTE TO APPLICANT: A valid photo (i.e.; passport, driver's license, authorization to work for alien workers, or other valid photo I.D.) must be presented when submitting this form to the department..

TYPE OF APPLICATION

NOTE TO HEALTHCARE PRACTITIONER: The above named person is applying for DPH&SS Health Certificate in the occupation category checked below.

☐ NEW APPLICANT

☐ **EATING & DRINKING/FOOD ESTABLISHMENT:**
- PPD skin test for TB – if positive, perform chest x-ray

☐ **COSMETOLOGY:**
- PPD skin test for TB – if positive, perform chest x-ray
- Certification of Examination
- Professional License

☐ **MASSAGE: (Two photographs required)**
- PPD skin test for TB – if positive, perform chest x-ray
- Certification of Examination

☐ **TATTOO:**
- PPD skin test for TB – if positive, perform chest x-ray
- Certification of Examination

☐ **INSTITUTIONAL (Nursing Home, Adult Care, Child Care, Correctional Facility):**
- PPD skin test for TB – if positive, perform chest x-ray
- Physician's Certification of Examination

☐ **LAUNDRY/DRY CLEANING:**
- PPD skin test for TB – if positive, perform chest x-ray
- Physician's Certification of Examination

☐ **THERAPEUTIC MASSAGE: (Two photographs required)**
- PPD skin test for TB – if positive, perform chest x-ray
- Certification of Examination
- Professional License

☐ RENEWAL APPLICANT

☐ **COSMETOLOGY:**
- PPD skin test for TB – if positive, perform chest x-ray
- Certification of Examination
- Professional License

☐ **MASSAGE: (Two photographs required)**
- PPD skin test for TB – if positive, perform chest x-ray
- Certification of Examination

☐ **TATTOO:**
- PPD skin test for TB – if positive, perform chest x-ray
- Certification of Examination

☐ **INSTITUTIONAL (Nursing Home, Adult Care, Child Care, Correctional Facility):**
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HEALTHCARE PROVIDER CERTIFICATION ON REVERSE SIDE →

HEALTHCARE PROVIDER CERTIFICATION

NOTE TO ALL HEALTHCARE PROVIDERS: Please review the following instructions before completing this form.

PPD TEST RESULTS: Report the result of PPD skin test by giving the date the PPD was given, the date read, and the measurement in millimeters (mm).

Section A: This section is to be completed only if the applicant is free of communicable diseases, including those for which screening is specified.

Section B: This section is to be completed only if the applicant is not free of communicable diseases, including those for which screening is specifically indicated. Applicants with positive PPD skin tests must be referred by their physician to their reference x-ray facility to have a routine chest x-ray performed to screen for active tuberculosis. This x-ray must be read and interpreted by a licensed radiologist and a written report prepared for the physician.

COMMUNICABLE DISEASE CONTROL (CDC) CERTIFICATION: CDC certification is to be signed ONLY by the CDC Tuberculosis Program Coordinator of the department upon completion of all the reporting requirements and after the CDC physician's medical evaluation certifies that the applicant has completed/or is currently under treatment and has been certified as non-contagious.

WARNING: THIS CLEARANCE IS NOT VALID UNLESS THE PRINTED NAME AND SIGNATURE OF THE PHYSICIAN/AUTHORIZED PERSON (INCLUDING TITLE) ARE PRESENT IN SECTION "A" OR "B" ALONG WITH THE PHYSICIAN'S/AUTHORIZED PERSON'S STAMP AND THE REQUIRED MEDICAL INFORMATION.

PPD TEST RESULT: Date Given: _____, Date Read: _____, Reading: _____ (mm)

PLEASE CHECK AND COMPLETE EITHER SECTION "A" OR "B" AS APPROPRIATE

I have performed the health screen tests indicated on the front of this form and find the applicant:

A

□ is free of the communicable diseases for which screening is indicated above for the occupation in which the applicant desires employment.

_____
Physician's or other Authorized Name (Print or Stamp)

_____
If not Physician, Title (Print or Stamp)

_____
Signature Date

This Applicant should go directly to the DIVISION OF ENVIRONMENTAL HEALTH at the Department of Public Health and Social Services in Mangilao to continue processing.

COMMUNICABLE DISEASE CONTROL CERTIFICATION

FOR COLUMN "B" TO THE RIGHT:

The applicant □ may □ may not

Be employed in the occupation indicated above as of this

Date: _____

_____
Signature: DPH&SS, CDC Certifying Officer

B

□ is **NOT** free of the communicable diseases for which screening is indicated above for the occupation in which the applicant desires employment.

Attached are the copies of the following indicated documents:

□ Physical Examination (Health Screen) Form
□ A written report of laboratory test results.
□ A copy of the official Radiological Report.
□ Other (Specify) _____

_____
Physician's or Other AUTHORIZED Name (Print or Stamp)

_____
If not Physician, Title (Print or Stamp)

_____
Signature Date

This Applicant should go directly to the COMMUNICABLE DISEASE CONTROL PROGRAM, ROOM 118, at the Dept. of Public Health and Social Services in Mangilao to continue Processing.

_____
FOR DEH USE ONLY:
Received by: _____

Date: _____

POSITIVE REACTOR STATUS REPORT

THIS FORM MUST BE <u>COMPLETED</u> AND <u>SUBMITTED</u> WITH THE TB EVALUATION CLEARANCE FORM <u>ONLY</u> IF THE PPD SKIN TEST IS POSITIVE.

NAME: _____ DOB: _____

ADDRESS: _____

ETHNICITY: _____ PHONE (HOME/WORK): _____

1. PPD Test: Date Given: _____ Date Rec'd: _____ Result: _____ mms

2. Chest X-ray: Date: _____ Normal _____ Abnormal _____
   **Note: Radiological Interpretation by Licensed Radiologist <u>Must</u> be attached.*

3. INH Preventive Therapy Offered: Yes _____ No _____

4. Patient is currently on INH Preventive Therapy at my clinic.

   Yes _____ No _____ Date Preventive Therapy Started: _____

5. If not on INH Preventive Therapy, please state reason:

   ____ a. Patient refuses INH Preventive Therapy offered.
   ____ b. Patient is over 35 years of age with no risk factor.
   ____ c. Other (Specify) _____

6. Patient cleared for work/school: Yes _____ No _____

7. Patient referred to DPHSS Communicable Disease Control Clinic for possible INH Preventive Therapy.

   Yes _____ No _____

8. Patient referred to DPHSS Communicable Disease Control Clinic for possible active TB.

   Yes _____ No _____

9. Comments: _____

_____ _____
Physician's Signature Date

_____
Name of Physician/Clinic (Print)